



Dodge County

2020 OPEN ENROLLMENT

HEALTH INSURANCE & FLEXIBLE SPENDING

October 28 thru November 8

What is open enrollment?

Open enrollment is your one chance each year to make changes to your health benefits without a qualifying event. Changes may include things like changing plans or adding/dropping dependents.

Dean Health Plan and Employee Benefits Corporation will be here on October 17, 2019 to meet with employees and answer questions on the health insurance and health savings accounts. Please contact Human Resources (920-386-3690) to schedule an appointment.

Please review the following benefit updates for 2020. You will find your enrollment forms for Health Insurance, Health Savings Account and Flexible Spending towards the back.

ALL FORMS MUST BE RETURNED TO HUMAN RESOURCES NO LATER THAN NOVEMBER 8, 2019 AT 4:00 P.M.

If you have no changes and everything is the same as 2019, you are NOT required to return these enrollment forms.

If you're enrolling in Flexible Spending, 2020 Enrollment forms must be returned to us.

Health Insurance:

2020 High Deductible H.S.A \$1500/\$3000 Plan(Proposed)						
Dean Health Plan		H.S.A. Funding			Monthly Premiums	
	Total Deductible	Employer Funded	Employee Deductible	Total Premium	Employer 88.0%	Employee 12.000%
Single	\$1,500.00	\$1,000.00	\$500.00	\$535.69	\$471.41	\$64.28
Family	\$3,000.00	\$2,000.00	\$1,000.00	\$1,339.22	\$1,178.52	\$160.70

2020 PPO(Out of Service Area) High Deductible H.S.A \$1500/\$3000 Plan(Proposed)						
		H.S.A. Funding			Monthly Premiums	
	Total Deductible	Employer Funded	Employee Deductible	Total Premium	Employer	Employee
Single	\$1,500.00	\$1,000.00	\$500.00	\$727.14	\$471.42	\$255.72
Family	\$3,000.00	\$2,000.00	\$1,000.00	\$1,817.85	\$1,178.53	\$639.32

2020 Low Deductible \$500/\$1000 Plan(Proposed)				
Dean Health Plan			Monthly Premiums	
	Deductible	Total Premium	Employer	Employee
Single	\$500.00	\$732.08	\$554.74	\$177.34
Family	\$1,000.00	\$1,830.20	\$1,345.18	\$485.02

2020 PPO(Out of Service Area) Low Deductible \$500/\$1000 Plan(Proposed)				
		Total Premium	Monthly Premiums	
	Deductible	Premium	Employer	Employee
Single	\$500.00	\$1,011.37	\$554.75	\$456.62
Family	\$1,000.00	\$2,528.42	\$1,345.18	\$1,183.24

***Note: Public Safety 2020 Premium Rates are yet to be determined.

For questions, please contact Dean Health – 800-279-1301 or www.deancare.com

Dental Insurance (No rate increase)

Not included in open enrollment

	Total Monthly Premium	Employer Paid (FT)	Employee Paid (FT)	COBRA
Single	\$32.97	\$29.18	\$3.79	\$33.63
Family	\$99.46	\$88.02	\$11.44	\$101.45

Health Savings Account – Employer Contribution (Proposed)

Year: 2020				
Active status employees will receive a quarterly HSA contribution on the below pay dates provided the employee is enrolled in the High Deductible Health Plan and has an established Health Savings Account (HSA).				
Quarterly Employer Contributions				
Paid on the first Pay Date in January, April, July and October				
Full time	Per Quarter Amount		Part Time	Per Quarter Amount
	Single	Family		Single Family
	\$250.00	\$500.00	.4-.59	\$125.00 \$250.0
			.6-.69	\$150.00 \$300.0
			.7-.79	\$175.00 \$350.0
			.8-.89	\$200.00 \$400.0
			.9-.99	\$225.00 \$450.0
Pay Dates: Jan 10; April 3; July 10; Oct 2				

If you are enrolling in the High Deductible Health Plan (\$1500/\$3000) and are eligible to open an H.S.A., you have two (2) options for your H.S.A. provider:

1. You may open an H.S.A. with your own financial institution (i.e. bank, credit union, etc.)
2. You may open an H.S.A. with Employee Benefits Corporation (EBC).

**Please be aware that if you want to open a Health Savings Account and are currently enrolled in the Flexible Spending Program, your account balance in your Flexible Spending must be at ZERO by December 15, 2019 in order to open an H.S.A. If your account balance is not at Zero, this will delay your employer contribution to your H.S.A. on January 10, 2020.*

You may also elect to contribute additional pre-tax monies along with the County's contribution to your H.S.A. The maximum amount for a single coverage plan is \$3550 per year and family is \$7100 per year. This includes the County's contribution.

If you are 55 years of age or older, there is a catch up provision which allows you to contribute an additional \$1000 per year. You can start and stop these additional contributions at any time during the year.

Pre-Tax or After-Tax

For all employees who do not return the Flexible Spending enrollment form by November 8, 2019 at 4:00 pm, your group insurance premiums (health, dental, and basic life insurance) will be deducted from your paycheck on a Pre-Tax basis.

If you prefer to have your premiums deducted after-tax, you must complete the Flexible Spending Account enrollment form and check the "After-Tax" box.

Flexible Spending Account (F.S.A.)

STANDARD FLEXIBLE SPENDING	LIMITED FLEXIBLE SPENDING	DEPENDENT DAY CARE
Only those enrolled in the Low Deductible Health Plan (\$500/\$1000) are eligible for this option. This can be used for medical, dental, pharmacy, and vision services). The grace period applies.	Only those enrolled in the High Deductible Health Plan (\$1500/\$3000) are eligible for this option. This can be used for dental and vision services only. The grace period applies	Expenses and the Direct Deposit options are also still available for you

For Health Savings Account and Flexible Spending Account questions, please contact:

Employee Benefits Corporation (EBC)

Phone: (800) 346-2126

Email: participantservices@ebcflex.com

Wisconsin Retirement Systems

General Employees:

Calendar Year	Employee Required	Employer Required	Total
2019	6.55	6.55	13.10
2020	6.75	6.75	13.50

Protective Employees with Social Security:

Calendar Year	Employee Required	Employer Required	Duty Disability	Total
2019	6.55	10.55	0.17	17.27
2020	6.75	11.65	0.09	18.49

Executive, Elected, Judges:

Calendar Year	Employee Required	Employer Required	Total
2019	6.55	6.55	13.10
2020	6.75	6.75	13.50

If you need any assistance completing the enrollment forms or have any questions, please contact Leann Schultz, Insurance and Benefits Coordinator or Sandy Milfred, Recruitment and Benefits Assistant. They can be reached by calling the **Human Resource Department at 920-396-3690**. Thank-You!



DUE DATE: NOVEMBER 8, 2019 AT 4:00 PM

Dodge County Dean Health Plan Enrollment Form

Employee Information:

Name: (please print) _____ Social Security No: _____ - _____ - _____

DOB: ____/____/____ Address: _____

Phone Number: (____) ____ - ____ Employee's Primary Care Provider: _____

Dependent(s) Information: (please print)

Dependent Name	Relationship	Social Security Number	Date of Birth	Sex	Primary Care Provider

Please select One (1) Health Plan, sign at the bottom and return to the Human Resources Department by November 8, 2019 at 4:00pm.

Note: Per the Affordable Care Act (ACA), you are required to return this form even if you are waiving health insurance coverage.

Please make your plan selection:

☐ – Waive

I choose to waive medical insurance coverage for the 2020 benefit year

Dean HMO Plans:

Low Deductible Health Plan (HMO \$500)

- ☐ – Single Deductible: \$500/\$1000
- ☐ - Family Coinsurance: 0% after Deductible
Out of Pocket Maximum: \$7,150/\$14,300
Copays: \$60 Emergency Room
RX: 3 Tier Select Formulary: Tier 1 - \$5, Tier 2 – 20% Coinsurance
(Max of \$75 per fill); Tier 3 – 40% Coinsurance (\$50 min, \$150 max per

fill)

High Deductible Health Plan (HMO \$1500)

- ☐ – Single Deductible: \$1500/\$3000
- ☐ - Family Coinsurance: 0% after Deductible
Out of Pocket Maximum: \$1500/\$3000
Copays: Not applicable
RX: 4 Tier HSA Formulary: Deductible/Coinsurance
(\$0 after deductible is met)
HSA Qualified

Dean PPO Plans (Only available to employees outside the Dean service area)

Low Deductible Health Plan (HMO \$500)

- ☐ – Single Deductible: \$500/\$1000
- ☐ - Family Coinsurance: 0% after Deductible
Out of Pocket Maximum: \$7,150/\$14,300
Copays: \$60 Emergency Room
RX: 3 Tier Select Formulary: Tier 1 - \$5, Tier 2 – 20% Coinsurance
(Max of \$75 per fill); Tier 3 – 40% Coinsurance (\$50 min, \$150 max per fill)

High Deductible Health Plan (HMO \$1500)

- ☐ – Single Deductible: \$1500/\$3000
- ☐ - Family Coinsurance: 0% after Deductible
Out of Pocket Maximum: \$1500/\$3000
Copays: Not applicable
RX: 4 Tier HSA Formulary: Deductible/Coinsurance
(\$0 after deductible is met)
HSA Qualified

I understand that the selections made on this form will confirm my plan elections for the 1/1/20 – 12/31/20 plan year and I will not be able to make any changes to these without a qualifying event.

Employee's Signature

Date



Health Savings Account Enrollment/Change Form Dodge County

Due Date: November 8, 2019 at 4:00 PM

Employee Information (Please Print Legibly)

Employee's Name		Date of Birth	Social Security Number
Home Address:			
Home Phone		Email Address (we do not share your email address)	
I am enrolling in a Health Savings Account:		I am changing my employee contribution:	
Effective Date (must be a Pay Date):		Effective Date (must be a Pay Date):	

OPTION 1: Employee Benefits Corporation (EBC)

☐ I elect to enroll in the Health Savings Account through Employee Benefits Corporation (EBC):

High Deductible Health Plan: ☐ Single ☐ Family

By affixing my signature below, I certify that the information provided on this form and any attachments, including my Social Security Number is correct, true and complete. I am covered, or will be as of the effective start date, by a qualified High Deductible Health Plan. I also certify I am not covered by any other health coverage that is incompatible with an H.S.A (including, but not limited to Medicare, TriCare, or a Health FSA), and I am not claimed by anyone else (other than a spouse) as a dependent for tax purposes. I am not subject to backup withholding because: a. I am exempt from backup withholdings or b. I have not been notified by the IRS that I am subject to backup withholding as a result of failure to report all interest or dividends, or c. the IRS has notified me that I am no longer subject to backup withholding. I understand that in the event of a mistaken contribution as defined in IRS Notice 2008-59, Sections 23-25 my employer may need to request that prior deposited funds withdrawn from my Health Savings Account in order to correct the error. I have reviewed and agree to the following Agreements and Disclosures that have been provided to me for my Health Savings Account: Custodial Agreement; Deposit Account Agreement; Truth in Savings Disclosure; Find Availability Disclosure Agreement; External Funds Transfer Agreement; and the Privacy Statement. I consent to electronic delivery of account statements and understand I can change delivery preferences once enrolled for online access. I appoint Avidia Bank as custodian of my Health Savings Account. I understand that I can revoke this authorization of appointment within seven (7) days from the date of opening by H.S.A. by mailing a written notice to Avidia Bank, PO Box 370, Hudson, MA 01749. I understand that if I separate from employment but choose to retain my H.S.A. through Employee Benefits Cooperation, I will be Subject to a \$2.50 monthly maintenance fee. I am a US Citizen or other US person as defined by the IRS.

OR

OPTION 2: Employee's Own Financial Institution Information

☐ I wish to use my own Financial Institution to set up my Health Savings Account:

High Deductible Health Plan: ☐ Single ☐ Family

Financial Institution _____ City _____ State _____ Zip _____

Account Number _____ Routing Number (exactly 9 digits) _____

Additional Election Amounts

Yearly Max. Employer+Employee: \$3550 Single \$7100 Family Age 55+ additional \$1000	Employee Contribution (per pay period)	Employee Contribution End Date	Employee Contributions Continuous
Pre-Tax H.S.A. Contributions			
Post-Tax Contributions			

Note: Post tax deductions should only be entered above if an individual is ineligible to make a pre-tax contribution to an H.S.A. (for example, a partner in a partnership or more than 2% share holder of an S corporation)

By affixing my signature below, I certify that I have examined this agreement and understand and agree to comply with the terms and conditions of the Plan. If this is a change in status, I certify that this change is consistent with the Qualifying event. I agree to hold my employer harmless from any liability to my participation in this plan.

Signature and Acknowledgement

Employee Signature	Date
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Flexible Spending Enrollment Form



EBC phone Number: 800-346-2126 or 608-831-8445

DUE DATE: NOVEMBER 8, 2019 AT 4:00 PM

Employee Information (Please Print Legibly)

Employee's Name		Date of Birth	Social Security Number
Home Address			
Home Phone		Email Address (we do not share your email address)	

Plan Benefits

Group Insurance Premiums (Health, Dental, Basic Life Insurance)

You are **Required** to Check One Box

☐ Pre-tax

☐ After-tax

IMPORTANT: If you do not return this form, your group insurance premiums will be deducted on a **Pre-Tax Basis**.

Are you or your family members participating in a Health Savings Account (H.S.A.)?

☐
Yes

☐
No

Standard Flexible Spending Account

For those enrolled in Low Deductible Health Plan

(Out-of-pocket expenses for medical, dental, vision, etc.)

Yearly Minimum amount is \$100; Yearly Maximum is \$2650; Grace Period Applies

\$ ÷ =
Plan year election amt No. of Paychecks Amount per Paycheck

Limited Flexible Spending Account ****ONLY FOR THOSE WITH HSA ACCOUNTS****

For those enrolled in Health Savings Account

(Out-of-pocket expenses for dental, vision, only)

Yearly Minimum amount is \$100; Yearly Maximum \$2650; Grace Period Applies

\$ ÷ =
Plan year election amt No. of Paychecks Amount per Paycheck

Dependent Day Care Expenses

OR \$2550 if married and file separate tax Returns

Yearly minimum amount is \$100; Grace Period Applies

Plan year election amt No. of Paychecks Amount per Paycheck

Direct Deposit (optional: complete banking information below to participate - authorization is in effect from plan year to the next)

Financial Institution City State Zip
☐ Checking ☐ Savings
Account Number Routing Number (exactly 9 digits)

Signature and Acknowledgement

This agreement will remain in effect for the Plan Year unless changed for reasons stated in the terms and conditions of the Plan (see HR or Dodge County HR webpage for details). By affixing my signature below, I certify that I have examined this agreement and understand and agree to comply with the terms and conditions of the Plan. If this is a change in status, I certify that this change is consistent with the Qualifying event. I agree to hold Employee Benefits Corporation and my employer harmless from any liability to my participation in this plan.

Employee Signature

Date